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GOVERNOR

STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE EMERGENCY MEDICAL SERVICES
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COMMISSIONER

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DIRECTOR

MEDICAL DIRECTION & PRACTICE BOARD MEETING
SEPTEMBER 21, 2005
9:30 AM – 12:30 PM—MDPB GENERAL MEETING
MINUTES

In Attendance: S. Diaz, E. Smith, P. Liebow, K. Kendall, D. Ettinger

Staff: J. Bradshaw, D. Corning

Guests: B. Zito, M. Sholl, P. Marcolini, G. Brockway, M. Day, R. Petrie (Ops rep), L. Metayer, S. Benton, J. LeBrun, D. White, J. LaHood, J. Regis, K. McGraw, J. Busko, N. Dinerman, D. Batsie, C. Moretto, D. Stuchiner, S. Kemmerer, J. Ontencgo, L. Hopperstead

A. Old Business

1. Introductions: New ED doc with EMS fellowship training at EMMC, Dr. Jonathan Busko
2. Minutes, June 2005 Meeting: review and acceptance: Motion, by Kendall, second by Ettinger, unanimous vote
3. Legislative-- Adjourned, Budget—Nothing new. EMS Study. 3 work groups have completed their work (Human Resources, Transportation, and Medical Control). Regulation & Policy continues its work on prioritizing the recommendations, then a complete summary of all work group recommendations will be compiled. Next phase will be taking the high priority items and drafting the goals, strategies, and action plans.
4. Electronic Run Reporting: Ben Woodard has been hired as the EMS Data & Preparedness coordinator. Work continues on the software configuration. Goal is to have the demo version of the web software in operation before the Samoset Conference – then other training will commence. Ben will be working on the project timeline and other logistical issues of this project.
5. CPAP update: Held over for next month
6. RSI: Held over for next month

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7. OLMC: held over pending EMSTAR committee report
8. Aeromedical field numbers from one year retrospective: Dinerman— understanding limitations of the data and originally a prospective look which then had to change to a retrospective format, here are the number of patients discharged from CMMC and EMMC over the fiscal year noted who arrived via helicopter from the field and were discharged within 12 hours with the numerator of all scene transports. No patients discharged from MMC within 12 hours. 2003: 6/187=3%; 2004: 10/242= 4%; 2005: 9/255=4%. These numbers are low compared to other programs, a majority are trauma calls, and we have no way at getting at under triage. As far as needing to drill down on these numbers further, probably not necessary since they are so low.
9. PIFT Update (this was after the Trauma protocol clarification): Marcolini, Corning, and Diaz will meet with McArtor and Gibbs from Maine Health to determine if we can develop PIFT but outsourcing a portion to the mutual benefit of all. Concerns raised about loss of MEMS control and proprietary issues. This has been previously discussed with Maine Health representatives and we will continue to be cognizant of such issues.
10. Trip Destination: Bangor area working out their procedures, not an issue in Portland. Lewiston/Auburn may have an issue but whether or not amenable via this group is doubtful. Will look for feedback if we can intercede, but this brought up the subject of where our boundaries exist. We cannot proscript hospital practice, but hopefully can offer input via our QI and medical direction processes. If issues do arise, try to utilize OLMC and the QI process to check for standard of care violations.

New Business

11. Go Box/Disaster Medicine: Regional Resource Center Presentation—Held over.
12. Clarification of Trauma protocol: Diaz presented the idea that we clarify the trauma protocol in that those who have physiologic or anatomic markers which make transport to a trauma center the best option for the patient, that transport to such a center include aeromedical help at the scene without involvement of OLMC. LeBrun queried as to why not all types of patients which is what her workgroup recommended, and that is a different issue which has no consensus or data to show improved patient care—that may come up later as a separate discussion but is very controversial. Motion by Liebow, second by Ettinger, with unanimous support.
13. Chest tubes and Non-PIFT paramedics: Non-PIFT paramedics are not trained in chest tube management. After discussion and help from Dr. Hopperstead in clarifying a subset of patients, patients with spontaneous pneumothoraces who are physiologically stable may be transported by non-PIFT paramedics

with a Heimlich valve in place. All other patients should have a PIFT paramedic or other appropriate personnel attending to the patient.

14. Update of Airway and 12 Lead EKG QI: Recommendations from the group on both the airway and 12 lead forms—will be carried to the State QI committee. LeBrun with concerns of how this flows. We have discussed a plan at State QI and with new employee, will revisit with Jay to see how we go forward. Once truly finalized, will bring to MDPB. Suggestion to bring to the State QI committee the addition to the top of the forms to indicate to check for ET tube placement via two confirmatory maneuvers.
15. Midlevel practitioners as service medical directors: The issues surrounding this are myriad and different criteria for oversight depending on the type of midlevel. Suggested that we wait for formalization of medical direction training and OLMC training and that such a program would include the midlevel practitioner. This program is due to be generated over the next year.
16. MDPB members: to select a portion of the protocol book to longitudinally be responsible for updates.
17. Diversion: Petrie brought up the issue of diversion. Diversion not supported by us and will bring to the Board of Maine EMS and see if we can politic with Maine Hospital Association and partner with Maine ACEP to drive a diversion process that makes sense.
18. Next Meeting October 19, 2005